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ABSTRACT

Establishing school-based drug prevention programs was the aim of the Drug-Free Schools and Communities Act of 1986 (DFSCA). The extent to which DFSCA-funded programs made a difference in helping states and localities prevent or reduce drug use and some of the effective prevention strategies and programs for use with school-aged youth are examined in this report. Site visits were made to 19 participating school districts to determine: (1) rationale for the adoption or use of chosen program components; (2) content, organization, and delivery of the prevention program; (3) types of evaluations the programs had conducted; and (4) the extent to which districts/schools were able to implement program activities as planned, and why. Key findings are presented under the headings of "Program Content," "Program Staffing", and "Evaluation." Overall, DFSCA was successful in encouraging these school districts to establish or expand their school-based prevention programs. Content and quality of the efforts varied. Factors that facilitated implementation, barriers to achieving full implementation, and needs for technical assistance are discussed. Attachments include DFSCA as amended in 1989 and a list of "Prevention Specific Curricula" used by the districts under review. (EMK)

School-Based Drug Prevention Programs: A Longitudinal Study in Selected School Districts

Local Education Agency Cross-Site Analysis

Final Report

U.S. Department of Education
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Executive Summary

Establishing school-based drug prevention programs was the aim of the Drug-Free Schools and Communities Act of 1986 (DFSCA).[1] The U.S. Department of Education (ED) sponsored a longitudinal study to (1) examine the extent to which DFSCA-funded programs made a difference in helping states and localities to prevent or reduce drug use and (2) identify effective prevention strategies and programs for preventing or reducing alcohol and other drug use among school-aged youth. The longitudinal study was a follow-up to the implementation study of DFSCA state and local programs which was conducted by Research Triangle Institute (RTI) in 1988-90.[2]

As part of the longitudinal study, RTI staff visited the 19 participating districts to determine the following:

- Rationale for the adoption or use of chosen program components;
- Content, organization, and delivery of the prevention program within the district and the key schools,[3] including differences and similarities among the schools;
- Types of evaluations the programs had conducted of the prevention program overall or any of the specific activities; and
- The extent to which districts/schools were able to implement program activities as planned, and why.

The methods used to accomplish these purposes included interviews with district prevention program coordinators, school staff (e.g., principals, teachers, counselors), parents,

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[1]The legislation was reauthorized as the Safe and Drug-Free Schools and Communities Act (SDFSCA) of 1994 (Title IV of Title I of P.L. 103-382) and includes additional activities aimed at violence prevention as well as drug prevention. This report refers to programs as implemented under the former legislation.

[2]Thorne, S.M., Holley, J.A., Wine, J., Hayward, B.J., and Ringwalt, C.L. (1991). *A Study of the Drug-Free Schools and Communities Act: Report on State and Local Programs* (Contract No. 234U-4337). Research Triangle Park, NC: Research Triangle Institute.

The purpose of the first study was to describe the early planning and implementation of DFSCA programs in the 50 states, the District of Columbia, and Puerto Rico.

[3]Key schools were defined as those with at least 25 study students. These were the schools at which we gathered prevention program data.

advisory council members, students, and other implementors of district prevention program components. Site visitors also reviewed program materials and observed various prevention activities such as classroom instruction, student support groups, assemblies, and special events.

Summary of Key Findings

This report describes the prevention programs of the 19 study districts and the services provided to students, staff, and the community from fall 1991 through fall 1993. The following are our key findings in the areas of program content, staffing, and evaluation activities.

Program Content

- The three components that most school-based prevention programs contained were student instruction, student support (e.g., student assistance teams, peer mediation, conflict resolution, counseling) and special events. Community members and organizations could be involved in any or all of these components.
- While a few districts created their own prevention-specific curricula, most made use of commercial and state or locally developed prevention curricula. Moreover, nearly all districts cited the use of academic textbooks as a source of prevention education material. Districts used a variety of curricula from several sources as appropriate for different grade levels.
- Some districts believed student support services were more important than student instruction for effecting long-term positive outcomes.

Program Staffing

- Overwhelmingly, classroom teachers were responsible for providing prevention instruction through the use of curricula.
- Districts varied substantially in the amount of the prevention program coordinator's time assigned to prevention (as opposed to other duties in the district). Overall, programs that appeared consistently well-implemented tended to be those whose prevention coordinators could devote 100 percent of their time to directing the program.

Evaluation

- Most districts had completed some form of needs assessment or program evaluation, relying primarily on prevalence surveys for their data. Few districts had specifically evaluated specific program components.

Implications

The Drug-Free Schools and Communities Act had been successful in encouraging these 19 study districts to establish or expand their school-based prevention programs. Prevention programs for alcohol and other drug use were operating in all study districts, although the content varied. Operationally, some districts and their prevention program coordinators had well-formulated prevention approaches that guided the choice of program components and their implementation, although others did not. The overall quality of a district's prevention efforts appeared to be related to the specific components that constituted the program and the extent to which those components were implemented as planned. Factors that seemed to facilitate the implementation of a district's prevention program were:

- The level of commitment of the program implementors,
- Leadership provided by the prevention program coordinator,
- Community involvement in the program and a sense of shared responsibility for preventing illicit drug use and for developing long-term solutions,
- Additional district staff to assist the prevention program coordinator, and
- Recognition at the district level of the importance of reinforcing a school-level commitment to prevention, through the use of school-based prevention coordinators, and through training of staff in prevention techniques.

The most common barrier to achieving full implementation of prevention programs was a lack of leadership by the program coordinator, a situation frequently exacerbated by the coordinator having other responsibilities within the district. Other barriers included:

- Program coordinators who did not consistently follow through to monitor what activities were being implemented in the schools,
- Lack of awareness by the program coordinators or other district administrators of the full spectrum of prevention strategies that might be employed,
- Community members who did not believe there were drug problems among their youth, and
- Other district priorities that interfered with prevention efforts, such as teacher contract negotiations, academic-related concerns, or a move toward site-based management.

These findings suggest that technical assistance should be provided to districts in the area of needs assessment and evaluation. Districts with limited resources could conduct a needs assessment to determine where the most serious needs are and focus their prevention efforts accordingly. Moreover, information could be disseminated to the districts on how to design and conduct an evaluation of key program components. Districts should be encouraged to spend some of their resources on evaluation and be shown how best to use the results for program planning. Additionally, program coordinators who lack awareness of the many approaches toward prevention could benefit from information on the range of possibilities used successfully by other districts.

Introduction

Research Triangle Institute (RTI) studied 19 school districts across the country as part of a 5-year longitudinal study for the U.S. Department of Education (ED) on the outcomes of local prevention education programs funded under the Drug-Free Schools and Communities Act of 1986 (DFSCA).[1] The primary purposes of the study were to:

- determine the extent to which DFSCA-funded programs had made a difference in helping states and localities to prevent or reduce drug use; and
- identify effective strategies and programs for preventing or reducing alcohol and other drug (AOD) use among school-aged youth.

Nineteen districts participated in the longitudinal study, selected to represent districts whose prevention programs comprised: (1) an extensive number of program components (e.g., student AOD prevention instruction in all grades, student assistance programs and/or student support groups, conflict resolution, and student leadership programs) or (2) a relatively small number of program components or components that focused on some, but not all, grades served by the district. The districts were located in all regions of the country and ranged from urban to rural, large (100,000 students) to small (2,214 students).

These districts, listed in the acknowledgments, agreed to participate in the study and allowed RTI staff to sample fifth and sixth graders in spring 1992, survey those students then and for three succeeding years, visit schools and classrooms, and interview district and school staff.

Table 1 presents selected characteristics of the 19 districts at the time of the site visits, including racial and ethnic distribution of enrolled students, urbanicity, overall district size and the number of students participating in our study. Districts are arranged by geographic region. Within each district, we initially aimed to sample 250 fifth graders and 250 sixth graders. The schools these students attended were identified as the initial "key" schools for the study. Sampled students were asked to respond to surveys each spring from 1992 through 1995. During the succeeding years of the annual student surveys, students moved from these schools

[1] Attachment A contains the DFSCA legislation.

Table 1: Characteristics of Study Districts and Students

Region of U.S.	Urbanicity	Number of Schools					Total Students 1993	Total Students in Study	Student Ethnicity (%)				
		Elem	Jr/Mid	High	Alt	Total			Black	White	Hispanic	Asian/ Pac.Isl.	American Indian
Midwest	Rural	5	1	1	0	7	2,900	420	3	92	1	<1	4
Midwest	Rural	2	1	1	0	4	2,200	318	<1	99	1	<1	<1
North	Urban	36	5	7	3	51	37,000	417	56	25	16	3	<1
North	Urban	45	17	15	1	78	47,000	794	49	42	7	<1	2
N. Central	Rural	3	2	1	0	6	1,900	240	<1	99	<1	<1	<1
N. Central	Suburban	10	2	2	1	15	11,200	520	2	94	1	3	1
N. Central	Urban	108	18	15	9	154	100,000	411	55	31	9	3	1
Northeast	Suburban	10	2	2	1	15	8,000	604	6	81	7	6	<1
South	Urban	18	4	5	2	29	25,000	673	33	61	5	<1	<1
South	Urban	64	17	15	4	100	64,000	650	57	43	<1	<1	<1
South	Suburban	25	9	7	0	41	4,500	511	25	68	<1	3	4
Southwest	Urban	44	11	5	3	63	70,000	662	2	81	13	2	3
Southwest	Urban	5	1	1	1	8	5,600	593	2	74	22	1	2
Southwest	Urban	20	5	3	1	29	21,000	775	1	39	58	<1	<1
Southwest	Urban	19	6	2	2	29	15,000	857	42	28	30	<1	<1
West	Suburban	11	2	2	1	16	14,000	418	7	77	12	2	1
West	Urban	85	17	14	3	119	86,000	544	1	88	8	3	1
West	Rural	7	1	1	1	10	4,500	715	<1	72	10	<1	17
West	Rural	6	2	1	0	9	4,600	850	<1	75	24	<1	<1

into other district schools.[2] For these subsequent years of the study, we defined key schools as those with at least 27 study students. These were the schools at which we gathered program information.

Each spring from 1992 through 1995, RTI staff members visited the 19 study districts to administer student questionnaires, the data collection tools for obtaining information on students' knowledge of, attitudes toward, and use of drugs. These visits lasted 4 to 5 days each, with administration of the student survey taking most of that time and controlling much of the visit schedules. The initial study design included interviews with district administrators, prevention program staff, teachers, and parents during the spring visits. However, given the limited amount of time staff had to conduct these interviews or observe classroom instruction, student support groups, training sessions, or other student activities, ED asked RTI to make an additional visit to each district during fall 1993 to gather more extensive program information. The focus of these visits was to examine the details of the prevention programs that could not be gleaned from extant information previously obtained from the districts.

Site visits primarily involved interviews with the districts' prevention program coordinators, key school staff (e.g., principals, counselors, teachers), parents, advisory council members, students, Drug Abuse Resistance Education (D.A.R.E.) officers, and community members. Site visitors also reviewed program materials and observed various prevention activities such as classroom instruction, student support groups, assemblies, and special events.

The products of the fall visits were case study reports of each of the 19 participating school districts[3] and this cross-site analysis report. The issues addressed in each case study included:

- Rationale for the adoption or use of chosen program components;
- The content, organization, and delivery of the prevention program within the district and the key schools, including differences and similarities among the schools;

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[2]If students moved out of the district, we did not attempt to include them in the years in which they resided outside of the district.

[3]Center for Research in Education (1996). *LEA Case Study Reports* (Contract No.: LC90070001). Research Triangle Park, NC: Research Triangle Institute.

- Analysis of existing evaluations of the prevention program overall or of specific activities; and
- The extent to which districts/schools were able to implement program activities as planned, and why.

The case study reports provided a database for relating program components to student outcome data, gathered through the student surveys, in the final project report.

The remainder of this report summarizes the rationale, program content, and evaluation issues addressed in the case studies and discusses the districts' success in implementing their prevention programs.

Program Rationale

The federal Drug-Free Schools and Communities Act has been remarkably successful in encouraging districts to establish or expand school-based prevention programs. Initiation of prevention programs in 16 of the 19 study districts was the direct result of federal funding provided by the DFSCA legislation. One objective of our case study research was to identify each district's rationale for initiating a prevention program and for adopting particular program strategies or components. We used this information as the foundation for assessing the extent to which original program goals had been realized.

Only three of the participating districts had implemented prevention programs prior to 1987. District 12[4], in response to a 1979 state mandate requiring all school districts to develop a drug prevention program, began a program that was entirely funded through local donations until the advent of DFSCA. District 13 started a prevention program in 1980 in anticipation of state legislation (subsequently passed in 1982) that would require districts to have instructional programs on prevention, chemical abuse, and dependency. District 4 initiated a community-based program to prevent unhealthy lifestyles by forming a county prevention task force in 1982, which later also served as the DFSCA advisory council.

Whereas all 19 study districts had developed written prevention policies as required by DFSCA,[5] only eight districts had clear, overriding approaches to guide the implementation of their drug prevention efforts. These approaches, developed by district administrators or the prevention program coordinators, were the basis for the identification of strategies, organizational structures, and specific components that comprised their prevention programs.

The prevention program administrators in three of these districts with clearly defined approaches believed that the communities had to be involved in prevention in addition to the schools. Moreover, these administrators thought that all children were at risk for AOD abuse and that all citizens needed to become educated about AOD problems in order to significantly

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[4]Because we want to focus on the characteristics of the districts and their prevention programs rather than their names and locations, we use numbers in referring to the districts in the body of this report.

[5]The policies typically forbid the use, possession, sale, or distribution of alcohol and other drugs by students and staff and also outline the consequences for policy violation.

reduce the potential for abuse. The prevention program in District 9 best exemplified this approach; a school/community organization directed the AOD use prevention activities for the school system and the broader community. The organization also served as the DFSCA advisory council, with eight subcommittees, five of which oversaw key components of the school prevention program. The remaining three subcommittees targeted parents, senior citizens, and school and business employees. Additionally, parent involvement in prevention activities was an important factor. Specific program components were designed to maximize student opportunities to serve as, and to bond with, positive role models. Program staff resisted pressure from some community members to use recovering alcoholics and drug addicts who were in recovery as presenters in the schools because staff only wanted to use models of drug-free lifestyles.

Although no community organization oversaw District 12's program, the community had consistently supported the district's prevention program for 15 years. The district's approach to prevention was to acknowledge that AOD problems existed in the community and to involve parents, students, school staff, and personnel from AOD treatment centers and other community organizations to address existing problems. The district program included a comprehensive array of program components, with varying components present in the individual schools depending on school needs.

Both Districts 4 and 13 also had very active, community-operated DFSCA advisory councils, but in these districts the councils did not include large numbers of parents from throughout the district. The Partnership of District 13, a nonprofit community organization founded in 1986, concentrated its efforts on crime, violence, and AOD use in the schools and the community. Many school-level drug-free activities had been initiated by the Partnership, which also sponsored parent programs and training. The Prevention Task Force in District 4 oversaw the district's prevention program and several program components resulted from Task Force ideas. Its approach of encouraging students to live drug-free lifestyles was reinforced by the program coordinator's refusal to accept financial support from a major brewery (the largest local employer) because to do so would have implied acceptance of the concept of responsible use, which would have conflicted with the district's no-use policy. A steering committee examined

and chose individual program components based on research regarding program effectiveness and the degree to which specific components best fit particular settings and populations.

Not all community-based programs were predicated on the belief that community involvement would benefit everyone. For example, although the program in District 16 used community resources to deliver prevention services, this approach reflected the program coordinator's belief that it was the most expedient method of providing services in a large urban area, rather than representing an expressed need to involve the entire community in prevention efforts. District and school personnel had limited involvement in the delivery of prevention activities.

Three other districts had very distinct approaches to drug prevention. In District 1, the prevention program coordinator believed that prevention of drug use was best achieved by addressing related problems such as academic failure and low self-esteem; the district's program therefore focused on at-risk youth. The approach of the District 14 coordinator was to develop prevention program components based on research identifying (1) the underlying risk factors for problems such as AOD abuse, pregnancy, delinquency, and dropping out; and (2) the protective or environmental factors (e.g., caring and support, high expectations, youth participation and involvement) that facilitate the development of youth who do not get involved in life-compromising problems. The District 14 program was characterized by support groups for students, teachers, and other staff. Additional training addressed educators' dysfunctional/distressed life circumstances to keep them from perpetuating dysfunctionality in classroom environments.[6] Finally, in District 8, school administrators believed that a minimal prevention program (i.e., primarily participation in Red Ribbon Week activities)[7] was adequate to address the needs of the community and its youth. In these eight districts, then, the specific components of the prevention programs reflected the overall purposes articulated in their approaches.

[6]The portion of this prevention program that provided assistance for school employees was supported by non-DFSCA funds.

[7]A week during which AOD use prevention is promoted through schoolwide assemblies in which students take a pledge to abstain from AOD use.

In the 11 districts with less-focused approaches to prevention program development, the individual program components they selected seemed to result from pragmatic concerns such as money and time, rather than from adherence to a well-articulated strategy for prevention programming. For example, in many districts, Lions Club or Elks Club members offered to pay for the *Quest* curriculum materials and training.[8] Without the financial backing of these community organizations, it is doubtful this curriculum would have been offered. In some cases, Lions Clubs were able to pay for training for only an initial group of staff; teachers not receiving this formal training either trained themselves or relied on their colleagues for assistance in using the materials — activities unauthorized by the curriculum's publishers.

Similarly, it is quite common for a law enforcement agency to fund the Drug Abuse Resistance Education (D.A.R.E.) program, which may help explain the popularity of this program in the study districts; some 16 of the 19 study districts used D.A.R.E. Other pragmatic reasons for use of specific curricula included ease of implementation or mandates by districts or states. Finally, some particular programs or activities were implemented because active individuals (parents, teachers, community members) were willing to invest the time to initiate them. In the following sections we examine the specific content of the districts' prevention programs, focusing initially on those activities directly targeting students. Other basic program components, such as community involvement and staff training, are also addressed.

[8]The *Quest* curriculum is not available for purchase without formal introductory training provided by Lions-Quest International. Follow-up training sessions are offered; both types of training are viewed by districts as relatively expensive, compared with most training they provide themselves.

Program Content

The DFSCA afforded local school districts considerable flexibility in deciding how best to pursue the goal of drug prevention, and that discretion was reflected in the diversity we found across districts with respect to the content of their drug prevention programs. The DFSCA identified 15 specific types of activities that federal funding could support. (See Attachment A for a copy of the DFSCA legislation.) Most of these activities were broadly focused on all students and included such activities as outreach, student instruction, guidance and counseling, family education, and referral for treatment. Special programs, such as model alternative schools for youth with drug problems and programs targeting student athletes, were also specifically identified by the enabling legislation as appropriate uses of federal funds. Finally, the legislation permitted school districts to implement "other programs of drug and alcohol abuse education and prevention, consistent with the purposes" of the Act (section 5125(a)).

To facilitate our examination of the programs implemented by the districts we studied, we categorized all student-focused activities into one of three broad areas, or program components:[9]

1. **Student Instruction**, which represents the use of drug abuse education and prevention curricula, textbooks, and other instructional materials;
2. **Student Support**, which includes peer mediation, counseling, and student assistance programs; and
3. **Special Events**, or events that occur on an infrequent basis, such as assemblies or Red Ribbon Week.

We then identified which of these components were considered by district staff to be essential, or key, to the achievement of each district's prevention purposes (see Table 2).

Student Instruction

All 19 districts in our study made use of some type of drug abuse education and prevention curriculum, although for some districts (Districts 3, 7, 8, and 14), curricula were a secondary rather than key component of the prevention program. Whether student instruction

[9]Staff training and community involvement, two other broad categories we used to classify DFSCA-supported activities, are discussed in subsequent sections of the report.

Table 2: Key Components of Study Districts' Prevention Programs[10]

District	Student Instruction	Student Support	Special Events	Staff Training	Community Involvement
District 1	X	X			
District 2	X				
District 3		X	X		
District 4	X	X		X	X
District 5	X	X			
District 6	X				X
District 7			X		
District 8			X		
District 9	X	X			X
District 10	X				
District 11	X				
District 12	X	X	X		X
District 13	X	X	X		
District 14		X		X	
District 15	X			X	
District 16	X				X
District 17	X		X		X
District 18	X				X
District 19	X	X		X	

was a primary or secondary component, it was the only program component that all 19 districts had in common. Instruction most often targeted the general population of students in each district; however, some districts offered separate instructional programs for specific groups of students, such as those who had violated a district's drug policy, potential dropouts, or students identified by staff as being most at risk for AOD use.

[10]As indicated in the table, a district may have had more than a single key prevention program component.

Districts relied on two sources of instructional materials for prevention education: (1) academic textbooks (e.g., health, home economics, physical education, science, social studies), which typically contained a chapter or two related to AOD use; or (2) specifically focused prevention curricula. Some districts relied solely or heavily upon academic textbook information as a source for prevention education. Based on the grade levels in which districts reported textbook use, and assuming that a different text was likely to be used at each grade level, we estimated that nearly 100 different academic textbooks were being used for prevention education in our study districts. Many districts' prevention program coordinators cited the use of academic textbooks by classroom teachers for drug prevention education as a way to infuse prevention instruction into other subjects. We observed that while reliance on academic textbooks was clearly an expedient way for a district to offer prevention instruction to students, some of the textbooks we reviewed were nearly 10 years old. Teachers stated that such prevention material was dated and did not adequately address students' current concerns. Furthermore, as we discuss in the staffing section, use of this material varied greatly from teacher to teacher.

Virtually all of the districts used some form of prevention-specific curricula in their programs (see Table 3). More than half of these 62 different curricula were commercially developed (39), while others were developed by school districts or other local entities (19), or by states (4). Districts used a variety of curricula from several sources as appropriate for different grade levels. In the next section we address the types of staff training, including training to use prevention-specific curricula.

Student Support

After curricula, student support activities ranked highest in frequency of use in the study districts, and nine districts cited student support activities as a key component. In most districts, these support activities included peer assistance programs, student leadership programs, student assistance teams, and counselor-led groups.

Among the study districts, peer conflict mediation and peer helping programs were the most common student support activity (11 districts). Typically, school staff asked students wishing to serve as peer helpers or mediators to complete simple application forms describing

Table 3: Supplemental Prevention Curricula Used by Study Districts[11]

Commercially Developed	
Al-Anon (1)	Just Say No (2)
Al-Ateen (1)	McGruff (2)
BABES (1)	Natural Helpers (4)
Building Self-Esteem (1)	Ombudsman (1)
CAP-Children Are People (1)	Operation Aware (1)
CHAMPS (2)	Peer Mediation (1)
Choice (1)	Positive Action (2)
Clear Choices (2)	Power of Positive Students (2)
CLOWNS (1)	Project Adventure (1)
COA-Children of Alcoholics (2)	Pumsey (1)
Conflict Managers (2)	Refusal Skills (1)
DARE (15)	Quest—Skills for Adolescence (11)
Discover (1)	Quest—Skills for Growing (1)
Education for Self-Responsibility (2)	Say No and Fly Away (1)
Esteem Builders (2)	Self-Esteem in the Classroom (1)
GREAT (1)	Skillstreaming the Adolescent (1)
Growing Healthy (1)	SRA Self-Development (1)
Here's Looking at You, 2000 (7)	STAGES (1)
Just for Me (1)	Too Good for Drugs (1)
	Turning it Around (1)
District/Locally Developed	
Change (1)	Peer Mediation (4)
Conflict Mediation (1)	PLUS (1)
Conflict Resolution (2)	Police Education Program (1)
Drug-Free Lifestyles (1)	Prevention is Primary (1)
EPIC (1)	Smile in Style (1)
IMPROV (1)	Straight Talk (1)
Inner - I (1)	Super Buddy (1)
Just for Kids (1)	Taking Charge (1)
Net Results (1)	Teen Counseling Course (1)
Peer Advocate Program (1)	
State-Developed	
Gatekeepers (1)	Minnesota Smoking Prevention (1)
I'm Special (1)	Strategies (1)

why they wanted to participate. Some districts had established criteria for participation, such as grades, attendance record, or parent permission. If more students applied than a program could accommodate, teachers or counselors were asked to review applications and make suggestions to the program sponsor (a school staff volunteer) about which students to include. Students selected to serve as peer mediators generally received initial training from the program sponsor

[11]The number of districts using each curriculum is given in parentheses.

or staff from the district prevention office. Peer mediators also participated in ongoing training, typically conducted by the program sponsor.

Students wishing to seek help from a peer mediator or peer helper could do so during specified times (e.g., lunch hour). Peer mediators were trained to refer students with problems the mediators could not handle to a counselor or another staff person. Some schools introduced the trained peer helpers in an assembly, through posters or flyers, or over the public address system.

Peer leadership programs were another form of student support implemented in five study districts. Such programs provided selected students with opportunities to serve as positive role models for other students; they often conducted schoolwide events with AOD prevention messages. Program participation was usually open to all students; sponsors often encouraged highly at-risk students to apply as a strategy for developing leadership skills in such students. Other districts had similar programs in which older students (junior/senior high school or upper elementary) conducted activities with younger students (elementary or lower elementary) related to drug use prevention. Participating younger students often were referred to the program by their teachers or counselors. A few districts operated such programs after school hours.

Modeled after employee assistance programs, student assistance teams identified and assisted students with AOD-related or other problems. Typically any building-level staff member could volunteer to serve on a team; usually teachers, counselors, school psychologists, and administrators served on these teams. Some districts provided training to team members prior to their service. Procedures for self-referral or referral by teachers, other staff, or parents were established by the district. Often team members completed referral forms, which might involve obtaining additional information about a student (e.g., grade records, attendance records, disciplinary records). Team members met to review the collected information and to make a recommendation regarding assistance for the student. Assistance often included a conference with a teacher or staff member, a parent conference with members of the team, enrollment in a district prevention program activity such as a support group, or a referral for professional diagnosis or evaluation. Follow-up reviews were also conducted.

As another way of providing student support, counselors often conducted small-group sessions on various AOD-related topics. Participating students typically met with the counselor

once a week during a specified class hour, and sessions lasted throughout a semester or longer. Elementary students identified for participation, typically through a student assistance program referral, usually were required to obtain parental/guardian permission to participate. A similar process worked at middle and junior high schools, although the older students were more likely than younger students to refer themselves to the group.

Two districts designed special support groups for students who violated the districts' drug policies. Violators were required to participate in these semester-long programs led by a specially trained counselor or prevention office staff member.

An overwhelming majority of the district programs' staff we interviewed believed that student support programs were beneficial to students for effecting long-term outcomes and perhaps provided a better means of preventing, and/or intervening in, AOD use than did student instruction. Advocates of student support groups stated that these groups helped students learn to make their own decisions and provided secure environments in which students could talk about their feelings, families, and problems. Student demand for participation in such programs was rapidly growing, and districts often could not keep pace in providing services because they lacked the necessary funding and staff. Most staff who participated in student support programs reported being overwhelmed by the problems students faced and by the amount of assistance students required to resolve the problems underlying drug use. Unsolicited student comments from the spring 1994 surveys for this study showed that students were interested in discussing the reasons they or other students take drugs. For example, students in six districts wrote comments on their surveys suggesting that we ask <u>why</u> people take drugs because "that's an important point." A few students provided the reasons why they had taken drugs: because of peer pressure and to relieve their "worries."

While some support groups were open to all students who believed they would benefit from participation in such a program, most student support programs were aimed at specific groups of students — those identified by school staff as being most at risk for AOD use. Two districts exemplified opposite ends of the continuum of attitudes about student support: (1) District 14, whose prevention program was based on a belief that student support is the best means of providing prevention education and early intervention for all students; and (2) District

17, which did not promote support groups, such as Children of Alcoholics, because parents might object.

The DFSCA supports such activities as identification of students with AOD problems and subsequent referral for treatment services. We found that such services were available in nine of our study districts.

Special Events

The third basic type of prevention program for students was special events. Virtually all districts offered some form of special event as part of their overall programs, but of the three student-oriented components (instruction, support, events), special events were less often identified by program staff as central or key to their overall program. Special events were a key component in just 5 of the 19 districts.

The most common form of special event that districts undertook was participation in Red Ribbon Week, a week in which AOD prevention is promoted through schoolwide assemblies in which students take a pledge to abstain from AOD use. Students and staff wear red ribbons to heighten awareness and promote prevention. In two of our districts (Districts 7 and 8), Red Ribbon Week activities were the key component of the prevention programs. In three other districts, Red Ribbon Week was a major focus and a primary source of community and parent involvement. On the other hand, two districts in our study did not observe Red Ribbon Week.

Other special drug-free events for students included assemblies with prevention-related themes; health fairs; special-occasion drug-free parties such as those following graduations and proms. Special drug-free events typically were open to all students. In the case of special assemblies, high school students often made presentations to students in an elementary, middle, or junior high school. If a speaker from the community made a presentation, all students in a school typically attended. Some districts targeted specific groups of students for participation in special events or programs, although attendance generally was open to all students. For example, at one elementary school in District 4, a teacher designed a tennis program for fifth- and sixth-grade students who were academically or behaviorally at risk. The program gave at-risk students a healthy alternative and encouraged social interaction with students not considered at risk. To remain eligible, participating students had to set academic or behavioral goals upon

entering the program, to meet weekly with the program sponsor to review progress toward their goals, and to maintain a "C" average. Tennis games were played after school 5 days a week for about an hour.

Summary

Instruction in AOD prevention, typically delivered to the general student population, was a key program component in most study districts; and student support activities, typically targeted to at-risk youth, constituted an essential program component in nearly half of the districts. Both types of activities were essential parts of the prevention programs in six districts. Special events were integral to overall prevention efforts in five districts. Three other categories of student-focused activities authorized by the legislation were rarely, if ever, the defining characteristics of prevention programs in our 19 study districts: special prevention programs for athletes (two districts), dropout prevention programs (one district); and model alternative schools for youth with drug problems (no districts).

Program Staffing and Staff Training

Successful implementation of student-focused prevention components appears to have depended upon the commitment of participating staff who delivered the program components and their expertise (acquired through preservice or inservice training). In this section we discuss the amount of time that prevention program coordinators were assigned to administer prevention programs, and the types of staff who were primary implementors at the school level. We then describe the type of training provided to the personnel in the 19 study districts.

Prevention Program Coordinators

Prevention program coordinators can greatly influence the tone of a district's program if they have a well-articulated approach guiding the configuration of components that constitute the program. Another major influence on the structure and operation of a prevention program is the priority it receives within the district. One dimension of the priority afforded to drug prevention efforts in the districts we studied was the relative amount of time available to the coordinators to perform prevention-related responsibilities, that is, the percentage of time district coordinators were assigned to AOD prevention activities (rather than other district responsibilities). While this percentage is related to district size (which determines level of DFSCA funding), there are some exceptions. For example, the prevention program coordinator for one of the largest districts in the study was assigned this responsibility only 15 percent of the time; one of the smallest districts provided 60 percent time to its coordinator. Seven of the prevention program coordinators were assigned to spend 100 percent of their time directing their districts' drug prevention programs, while six spent 45 to 75 percent of their time on prevention efforts, and six other prevention program coordinators spent one-fourth time or less. In some of the districts where the prevention program coordinator's assignment was 45 to 75 percent time, additional district-level staff resources were available to assist them. For example, in District 5 (with 50 percent time for the coordinator), two other district-level individuals each contributed 5 percent of their time to coordinate aspects of the prevention program; and in District 9 (with 45 percent for the coordinator), an assistant worked 70 percent time on prevention activities. Other roles held by those coordinators who devoted less than quarter-time to prevention included

counselor, superintendent, associate superintendent, dropout program coordinator, federal programs coordinator, and nurse.

There appears to be a relationship between the amount of time prevention program coordinators devoted to directing their programs and the overall level of program implementation. Most of the districts in which the prevention program coordinators were assigned full-time had programs that offered prevention instruction in all grades, provided extensive training for prevention staff, and offered a number of student support groups.

School Staff

The primary implementors of school-level prevention programs in our participating districts fall into three categories: teachers, student support staff (counselors, student assistance program team members[12]), and D.A.R.E. officers.[13] As mentioned, the two student-focused components that defined the prevention programs in most study districts included instruction, which typically was delivered by classroom teachers, and student support activities, typically delivered by counselors or teachers. D.A.R.E. officers were considered primary implementors in several districts that relied heavily on the D.A.R.E. program to provide prevention education to students.

For the most part, classroom teachers were responsible for providing prevention instruction through the use of a curriculum (15 districts). In five districts, health teachers delivered this instruction; in the remainder, other teachers delivered it. Heavy reliance on classroom teachers to implement prevention instruction seems to have resulted in inconsistent delivery of prevention information because teachers saw it as "just one more thing to add to an already full school day." This was especially true at the high school level, where several prevention program staff from various districts doubted that teachers were regularly integrating prevention instruction into academic courses, unless the courses were health or physical

[12]Student assistance team members typically included a building-level administrator, teachers, a counselor, a school psychologist, and/or a nurse.

[13]Drug Abuse Resistance Education, or D.A.R.E., typically consists of classroom lessons for fifth and/or sixth graders presented by specially trained law enforcement officers.

education. Often teachers had discretion to decide how much time to devote to prevention instruction.

Most districts (15) relied on counselors, student assistance program team members, or staff from community agencies as primary providers of prevention-related student support. Reliance on counselors may have limited the availability of support in some schools, however. Most elementary schools did not have full-time counselors, and some had no site-based counselors even part-time. Thus, only limited prevention-related student support was occurring, given the number of schools each counselor had to serve. At the junior and senior high school levels, several counselors reported that their students faced complex problems such as child abuse, teen pregnancy, divorced and single-parent families, and AOD use. These challenges, combined with student-to-counselor ratios approaching 500:1, impeded counselors' efforts to focus on prevention; they found they had time for crisis management only.

The problems faced by counselors and teachers in most schools were alleviated somewhat in a few districts through stipends or release time offered to school staff who assumed responsibility for prevention program coordination at the building level. For example, in District 14, the key program component was the "CARE team" — support groups conducted by trained school staff; each school's volunteer CARE team coordinator received a stipend for coordinating prevention activities at his/her school. Moreover, teachers who had been trained to conduct support groups received release time from their normal duties to lead the groups, and they received stipends based on the number of support groups they conducted.

District 12 avoided the problems faced by program staff in most schools through the additional funding they received from county taxes (discussed more fully in the community involvement section of this report). Using these funds, the district prevention office employed 19 full-time school drug advisors to implement prevention program components in the schools. All drug advisors were responsible for three to nine schools, and they were heavily involved in providing training, support, and leadership to students, staff, parents, and community groups. Drug advisors also coordinated the teaching of prevention curricula with school staff. The strength of the prevention programs in Districts 12 and 14 resulted, in part, from the efforts of the school drug advisors and CARE team coordinators in these districts, which came about because of local resources that supported their functions.

Many districts had a variety of other school-based implementors for secondary prevention program components; these included D.A.R.E. and other law enforcement officers, parents, paraprofessionals, community organization staff, part-time school coordinators, and advisory council members. For example, in District 18, each school had a full-time caseworker provided through the district's dropout prevention program, a program aimed at decreasing the dropout rate by increasing each student's chances of succeeding in school.[14] In a later section we discuss extensively community involvement in district and school prevention programs, including service delivery functions.

Clearly, teachers and counselors were responsible for the vast majority of prevention education occurring in the study districts, and these responsibilities were generally in addition to their regular workloads. Especially in the case of teachers, unless they viewed prevention instruction as a priority, delivery could be sporadic because prevention education was "just one more thing to do." Few districts offered stipends or release time to support educational personnel for time spent coordinating prevention program components. Only District 12, through the community's financial support of the prevention program, could afford to hire full-time school drug prevention staff to oversee the prevention activities in all schools. Hence, prevention education often depended on the commitment of each individual staff member and on a personal belief in the importance of providing such instruction on a regular basis. It is thus not surprising that districts tended to welcome any community involvement, such as instruction provided by D.A.R.E. officers, to complement the efforts of school personnel.

Staff Training

All 19 districts we studied conducted prevention-related staff training, but only 4 of the 19 districts (see Table 2) viewed staff training as a key component of their prevention efforts. In this section we first discuss the efforts of the four districts that emphasized staff training. We then describe the training offered by the other study districts.

In Districts 4 and 14, staff training typically addressed student support activities. In District 4 this training included conflict mediation, refusal skills (open to parents as well as

[14]This dropout prevention program was funded through an interagency agreement at the state level between the employment commission and the education agency.

staff), and improvisational theater for staff and students. District 4 also provided curriculum-related training; but District 14 did not sponsor any prevention-specific curriculum training, other than that sponsored and paid for by the local Lions Club. Rather, training opportunities in this district focused on key components of the district's prevention program: preparing staff to serve as members of school-based student assistance teams and to facilitate student support groups. Staff in both of these districts could progress through different levels of training (e.g., introductory, advanced), and training sessions in these districts tended to be intensive (several full days) and offered regularly.

The focus of staff training efforts in District 15 was to make all staff aware of key issues in AOD prevention. All new staff had to receive baseline substance abuse training (2 hours of instruction); such training for existing staff was voluntary. District 19 provided extensive inservice training sessions on AOD prevention annually, instructing teachers and staff in topics that included drug awareness, infusion of prevention education into academic subjects, and delivery of a prevention-specific curriculum. This district also provided ongoing training to the school-level program coordinators throughout the year.

Staff training available in the other districts typically focused on these three areas: prevention-specific curriculum, general AOD information, and student support. We discuss each of these below.

Most districts offered training for prevention-specific curricula selected by the district (e.g., *Quest* and *Here's Looking at You, 2000*). Training sessions for these curricula usually were conducted by program developers, district staff who had been trained by developers, or state education agency staff.

Study districts offered prevention-specific curriculum training either annually or one time only. In the case of the latter, when new teachers or veteran teachers not previously trained in a curriculum became interested in using a program for which training was no longer provided, they had to rely on their colleagues for assistance and spend time familiarizing themselves with the materials. In some instances, districts attempted to train all teachers using a curriculum in one of two ways: train a core group of teachers (one from each school) who then trained the teachers in their respective schools, or train different grade levels of teachers each year until all

teachers using a curriculum were trained. Most curricular training was completed by teachers of kindergarten through grade 8.

In addition to curriculum training, most districts offered training sessions to personnel at large on AOD-related topics that ranged from drug awareness and intervention to gang and violence prevention. These sessions usually were conducted annually by district staff or a local community organization. Occasionally, outside agencies such as a DFSCA Regional Center provided such training. Participation by staff typically was voluntary.

Twelve districts provided staff training opportunities in the area of student support activities. Student assistance team members often received training, as did individuals who implemented other student support activities such as conflict mediation or peer helping programs. Most student support training was ongoing rather than a one-time occurrence. District prevention staff often conducted this type of training.

Finally, six districts offered training for parents, either because the parents volunteered to administer or assist with a program's implementation (for example, teaching or helping to teach drug awareness and prevention classes) or because the training topics included parenting skills, identification of chemical use, or prevention strategies. Parent training opportunities were offered continuously and on a one-time basis. Low attendance by parents often led districts to drop such training opportunities or prevention education sessions. An exception was District 9, where prevention staff changed their tactics to target a larger number of parents to attend their parenting seminars (see evaluation section for further discussion). District 14 had an overwhelming response from parents wishing to participate in student support training, but due to shortages of funds and staff at the district prevention office, the district discontinued the effort.

Community Involvement

The DFSCA mandates community involvement as an important part of the overall effort in the fight against drug and alcohol use among youth. Community involvement in alcohol and drug prevention programs in the 19 study districts took many forms and involved an array of organizations. Involvement also took the form of an advisory council providing oversight and advice on district efforts, program development, and delivery. In addition to parents, the types of groups involved in prevention activities included nonprofit organizations (e.g., drug rehabilitation facilities), law enforcement agencies, state and local human service agencies, and local businesses.

Of the 19 districts we studied, 7 identified community involvement as a key component of their overall prevention program, although all districts in the study had some level of involvement from the broader community. In general, the districts that integrated community efforts into their overall prevention planning substantially expanded their capacity to achieve their program objectives. In contrast, districts that did not actively seek support from the community ended up with fewer community resources to establish a solid school-based prevention program. In the remainder of this section we address the involvement of parents and various agencies in supplementing the efforts of district and school staff.

Parents

The majority of the staff we interviewed in most districts stated that involving parents in prevention activities was one of the toughest challenges they faced. Involving parents was difficult for several reasons: (1) most parents believed their children were not using or selling drugs; (2) parents had limited amounts of time to give, especially among single-parent families; (3) some parents were occupied with problems of their own, including drug use, divorce, or domestic violence; (4) many children were from nontraditional families headed by grandparents or other relatives, or foster parents; or (5) parents were unfamiliar with the prevention program. When parents were involved in district prevention programs, it was typically through volunteering to help with special events, such as Red Ribbon Week, drug-free graduation parties, health fairs, and the like. Occasionally, parents provided prevention instruction to students or

were themselves recipients of prevention programming. District 12 parents worked for passage of the 1992 county property tax to continue funding the district's prevention program.[15] In addition, thousands of parents had participated in prevention program-sponsored training, classes, and conferences. District staff published and distributed a monthly prevention newsletter for parents and students. Family Zoo Day was a major prevention-oriented activity sponsored by the prevention program at a local zoo that drew hundreds of students and their families together for participation in prevention activities.

In District 17, parents initiated efforts to implement the *Just Say No* curriculum at the elementary school and provided the impetus for teaching the classes during the school day rather than after school. Parent volunteer groups taught the curriculum once a month during health classes. In one of the district's schools, staff and minority parents succeeded in several efforts to improve school-community relations and implement drug prevention training by parents and for parents throughout the community.

Law Enforcement Agencies

The most frequent type of community involvement we found in the study districts was use of police officers in the classroom to deliver the D.A.R.E. program. This program, a key student-focused activity in six districts, typically consists of a one-hour-long classroom session per week for 17 weeks, during which the officers provide information on drugs, ways of resisting peer pressure to use drugs, and ways to improve self-esteem. The program is aimed at students in the last year of elementary school, either fifth or sixth graders; however, four study districts also used the program in other grades (kindergarten through grade 7).

Whereas D.A.R.E. frequently was a part of most (16) district prevention efforts, not all program staff viewed the D.A.R.E. program as an essential component of their overall program, and opinions varied on the relative effectiveness of D.A.R.E. Program detractors from visited districts commented that the D.A.R.E. curriculum appeared to have no effect on drug use but did improve some students' attitudes toward police officers. Supporters frequently cited the

[15] An increase to the county property tax to support the district's prevention program was proposed and placed on the local ballot in May 1987. The tax passed and from 1988 through 1992, it supported the prevention program in the amount of $500,000 each year. The tax was presented for renewal in May 1992, along with several other proposed taxes to benefit the schools. The drug prevention program tax was the only one that passed, with funding for the district increased to $750,000 per year for the next 5 years.

students' enthusiasm for the program and the commitment of the officers, many of whom ate lunch with the students on the day that instruction occurred; these staff praised the program, reporting that it effectively provided AOD information, strengthened student self-esteem, and helped students trust law enforcement officers. Several teachers and administrators believed the program should be expanded to other grades. We observed that in many districts, staff seemed to like D.A.R.E. because police officers took on the burden of prevention instruction; teachers did not have to prepare prevention-related lessons, and they often used the D.A.R.E. session time to attend to other duties.

Programs similar to D.A.R.E. were a part of prevention efforts in several districts. Examples include the Gang Resistance Education And Training (GREAT) program in District 1 and the Police Education program in District 5. In District 13, the police department sponsored a 7-week chemical awareness program for teens under the age of 18 who were arrested for the first time and had no known AOD problems. Also, District 6 employed 15 full-time school resource officers (SROs), who were civilian security personnel trained in the Mendez methodology of prevention education.[16] Each middle school and high school had its own SRO, and six SROs had rotating schedules to serve the 18 elementary schools. All SROs assisted classroom teachers, upon request, in the delivery of the Mendez curricula. In several elementary and middle schools, SROs conducted a one-class session developed by the district to address drug laws and identification of drugs and drug paraphernalia.

Nonprofit Organizations and Human Service Agencies

Fifteen districts cited the involvement of nonprofit organizations or human service agencies in their prevention programs to provide student counseling, instruction, mentoring, and family education programs. The programs discussed below are examples of districts that have integrated various types of community assistance into their overall prevention efforts.

In District 5, the Bridge, a nonprofit youth and family service agency, operated the Family Resource Center at a key elementary school, provided student support through a series of

[16]The district used two curricula published by the Mendez Foundation: (1) *Too Good for Drugs*, for students in kindergarten through grade 6, focuses on increasing student knowledge, self-awareness, and refusal skills; and (2) *Clear Choices*, taught in grades 7 through 12, emphasizes gateway drugs, peer pressure, accurate information, decisionmaking skills, and alternatives to using drugs.

AOD counseling lessons in the middle schools, and operated an outreach program for at-risk elementary students. Street Ministries, another nonprofit group, conducted an educational program for violators of the district drug policy, along with their parents.

The Partnership (a nonprofit corporation in District 13) concentrated its efforts on crime, violence, and AOD use in the schools and community. The Partnership facilitated the gathering of community resources to identify and address community problems; members were actively involved in school prevention program development and operation.

In District 10, the state's Division of Families and Children, in association with the state's probation department, provided an in-school counselor to assist elementary students who had behavioral problems and were at risk for AOD use. Another aspect of this same alliance of agencies was a mandatory counseling and education program for parents who were served by, or involved with, either agency.

In District 14, staff from Families and Youth, Inc. (FYI), assisted counselors from a key middle school to conduct support groups for students at risk for AOD use. FYI staff also conducted summer activities and a parent education program for participating youth. Enrollment priority was given to students with probation officers.

In contrast, the prevention program coordinator in District 16 relied heavily upon community organizations to provide school-based prevention activities and staff training because he believed it was the most efficient way to supply prevention services to a large urban area. Prevention programs led by the contracted organizations were offered to individual schools on a first-come, first-served basis. Although this arrangement did not allow all schools to be served annually, without the involvement of these organizations, student instruction would have been limited to D.A.R.E. (only in some schools) and information in academic textbooks delivered at a teacher's discretion. In this district, the use of community resources seemed to take the place of establishing a school-based prevention program.

Community Councils or Advisory Boards

The DFSCA advisory councils in study districts included parents, teachers, district administrators, students, clergy, and representatives from business, civic, law enforcement and community organizations. Most councils met quarterly and their responsibilities included

reviewing DFSCA applications, making suggestions to the prevention program coordinator about prevention programming and policy, publicizing the program, and facilitating access to community resources if needed. In the two districts described below, these or similar councils were heavily involved in overseeing a prevention program or program development activities. They exemplify community involvement in prevention programming.

The DFSCA advisory council in District 4 was an unusual example of long-term community council involvement in prevention. In 1982, a community task force was established to prevent unhealthy lifestyles, including AOD use. The task force coordinated prevention activities across schools and the community, publicized events, and conducted fund-raising. The task force had initiated several programs and annually funded private and public school AOD prevention projects. The governor cited the task force as the state model for community-based prevention programs.

The school-based prevention activities in District 9 were managed by a local organization that also directed AOD prevention activities for the broader community. Together the elementary and secondary school boards established a community substance abuse program to coordinate comprehensive program and community activities for kindergarten through grade 12. The organization members also served as the DFSCA advisory council; a district superintendent headed the council and served as administrative agent for the DFSCA funds; and the prevention program coordinator managed the day-to-day operations of school activities. Committees of the council governed aspects of the school's prevention program, including curriculum, student assistance, peer counselors, D.A.R.E., and a special prevention program for athletes.

Local Businesses

Thirteen of the 19 study districts cited financial and in-kind contributions (e.g., free use of facilities for prevention-related activities) from local businesses for special prevention events or activities such as Red Ribbon Week, field trips, and summer camps. Whereas program coordinators appreciated this support, many stated they would have preferred businesses to offer instead their employees' time to assist with prevention activities. One district that enjoyed such support was District 12. All their schools had at least two "Adopt-a-School" business partners whose employees tutored and mentored students. Some businesses adopted specific schools;

others supported a certain prevention program component (e.g., supervising extracurricular activities) in several schools.

Summary

Community involvement in most aspects of district prevention programs took many forms. A notable example of community support was found in District 12, where the community at large had continuously shown its support for a comprehensive prevention program. Community donations largely supported the program between 1979 and 1987. Despite the arrival of DFSCA funds, voters passed a property tax that provided substantial additional funding for the prevention program after 1988.

The prevention programs in Districts 4, 9, and 13 were characterized by the belief within these communities that prevention education is the responsibility of all community members. The prevention programs in these three districts benefitted from the oversight of a community organization or task force that ensured coordination of school and community resources to deliver needed programs and services.

Evaluation

The 19 districts we investigated had conducted a variety of evaluation activities since initiating AOD prevention efforts, including needs assessments and program evaluations, and there was a wide range of activity within these two areas. Most districts undertook evaluation efforts that were minimal at best, while some sites conducted evaluations that were extensive, well-focused, and useful.

Our discussion of evaluation addresses: (1) needs assessment, which includes drug use prevalence surveys, attitude and behavior surveys, and other formal needs assessment activities; and (2) program evaluation, which includes prevalence surveys conducted over several years to determine any change in AOD use patterns among youth, and surveys of program participants and implementors to assess the effectiveness of one or more specific program components, such as curriculum, counseling, or staff training. We conclude our discussions of assessment and evaluation with a few general observations about how the results were used to develop and operate effective drug prevention programs.

Needs Assessment

Under Part B, section 5126(a)(2)(D) of DFSCA, local education agencies were required to "describe the extent of the current drug and alcohol problem" in their schools as part of districts' applications to receive DFSCA funds. The law did not specify the type of needs assessment activity to be conducted, and we found that all districts had conducted informal needs assessments periodically. Prevention program coordinators reported having ongoing conversations with members of the community and school staffs to keep abreast of prevention needs.

In this section we describe the more formal efforts 15 districts had made to assess the level of need for prevention among their communities and youth, and in some cases, to identify the specific grade levels or activities where the need was greatest. We also discuss eight districts that reported how the information gathered was used in program planning or improvement, and we describe the barriers encountered by three districts that conducted needs assessments.

Of the 15 districts that reported a formal needs assessment activity, surveys conducted by districts to determine (1) needs, (2) prevalence of AOD use, or (3) attitudes toward AOD, were the most common (nine districts), followed by district participation in statewide prevalence surveys (four districts); two districts conducted community needs assessments. The majority of needs assessment activities in these 15 study districts occurred in the late 1980s. Generally, students in grades 6 through 12 completed AOD prevalence or attitude surveys; in two districts, fifth graders participated in such surveys, and fourth graders also participated in one district.

Of the 15 districts that conducted formal needs assessment activities, only eight districts used their needs assessment results for program development, for implementation, or to verify the need for a prevention program. We outline the assessment activities and their use by these districts below.

District 3. A sample of students in grades 7, 9, and 11 participated in the statewide school year (SY) 90-91 American Drug Survey. One survey finding indicated an increase in AOD use between grades 7 and 9 compared with previous years. The district used this information to develop a grade 8 prevention curriculum and piloted its use in physical education classes at one middle school in SY91-92.[17]

District 5. The local substance abuse commission conducted a community-wide needs assessment in 1990, surveying parents and high school students. The results showed that alcohol use was higher than state and national averages, while other drug use was slightly lower. Respondents attributed the findings to the ready availability of alcohol within the community. The district used the results to demonstrate to the community and funding organizations the need for a comprehensive prevention program in the schools.

District 8. In SY90-91, the Northwest Regional Education Laboratory conducted the first district-sponsored survey of the district's students in grades 6, 8, 10, and 12. The results showed a small problem with AOD use in grades 6 and 8, and a much larger problem in grades 10 and 12—up to 37 percent of 10th- and 12th-grade students used AOD. The district reported using the survey results to choose new prevention program components, including a new curriculum in the elementary schools, and to update other curriculum materials for elementary and junior high schools.

[17]The middle school that piloted the curriculum continued its use in subsequent years.

District 9. The district surveyed students in grades 5-12 in SY89-90 to determine their need for drug prevention education. The students ranked 45 "areas of need": middle school children identified prevention of AOD use as their top need, while high school students ranked it ninth, behind academic and career-related concerns. Program staff interpreted the results as affirming the need to continue and expand the prevention program, especially for the middle schools.

In 1991 the district completed a special survey of student athletes in grades 7-12 regarding AOD use during sports seasons. The results confirmed the need for a drug education program specifically for athletes. Thus, in SY92-93 the district implemented a program in the junior and senior high schools to reduce alcohol use among athletes, using the results of the 1991 survey as a baseline for assessing program effectiveness.

District 12. In 1991 a nearby state university conducted three drug use and attitude surveys for the district, with the results used to identify and target program areas for improvement. For example, alcohol and tobacco use were identified as the biggest problem areas, particularly in grades 5 and 6. In response, the drug prevention staff enhanced the alcohol and tobacco prevention efforts in those two grades through school and parent programs and training.

District 13. In SY89-90 and SY91-92, district students in grades 6, 9, and 12 completed a survey developed by the state educational agency to assess needs for prevention education. The findings showed that the needs of the district's students were typical of students statewide. In general, the survey indicated that if students obtained information about alcohol and drugs from their parents or from the school, they were less likely to develop risk behaviors and use drugs than if they obtained information primarily from their peers. The district used the information as baseline data to assist educators in developing innovative curricula and programs and to develop hypotheses and research ideas to further understand AOD use and abuse.

District 15. In 1991 the National Center on Education and the Economy and the district's Drug and Alcohol Office conducted a needs assessment that led to staffing changes and new teacher training. Additionally, a local university completed a needs assessment of the high school curriculum for alcohol, substance abuse, and AIDS education. A final report to the

district was submitted in late spring 1993 and the prevention program coordinator reported that the results would inform program modifications in future years.

District 19.[18] In collaboration with a DFSCA Regional Center, the district asked administrators, prevention staff, and advisory council members to identify program needs. Planning, student assistance programs, curriculum integration, and gang and violence prevention were identified. Additionally, the Regional Center conducted several school-based needs assessments for many of the district's public and private schools. The district responded to the results of these assessments by providing staff training sessions on the topics identified by the assessments. It also intended to use the results to support long-range planning for the district and the schools.

In spring 1993, a middle school participating in the study surveyed (1) students regarding their attitudes toward and use of AOD, (2) students' families about AOD use in families, and (3) staff regarding awareness of student AOD use and whether staff knew how to respond to such use. In response to the results, which indicated that few students were using AOD but abuse was occurring in some families, the school produced an AOD resource guide and distributed it to parents.

Summary

The eight districts that described their use of needs assessment results used those results to (1) pilot or develop a curriculum to meet a specified need, (2) implement prevention-specific curricula that were commercially available, (3) conduct staff training, and (4) demonstrate the need for school prevention programs.

Three districts conducted various needs assessment activities but encountered barriers in using the obtained information. In District 10, the district conducted a needs assessment among staff and students in 1989, but a lack of funds and staff precluded making any of the changes suggested. Although District 8 prevention staff used survey results to choose new program components, district efforts to increase AOD education continued to be hampered by parental

[18]This district suffered from management problems that became acute in SY90-91, when the program had accumulated a significant sum of unobligated DFSCA funds. In response, the state instructed the district to seek assistance from a DFSCA Regional Center to help focus its prevention program; at the time of the fall 1993 site visit, the Center was continuing its work with the district's prevention program.

views that it has "someone else's kids who use drugs." Similarly, in District 7, despite prevalence survey results showing AOD use among white students, administrators were late in acknowledging that their initial perception that AOD use was confined to the Native American population may have been inaccurate. It was unknown at the time of the fall 1993 site visits whether this change in perception would lead administrators to expand the district's prevention efforts beyond Red Ribbon Week activities, which constituted its primary prevention program.

It is possible that the four districts that did not report conducting formal needs assessment activities, and the seven districts that did but had not cited use of the results, could still benefit from technical assistance in these areas from the Regional Centers or the states. Whereas the 19 study districts were not a representative sample of all district prevention programs, in the area of needs assessment, it appears that a majority of study districts, and perhaps districts in general, could improve their techniques for obtaining and using needs assessment results. Additionally, in some cases, the amount of prevention funds they received in a given year appears to have been a factor in whether or not districts (1) conducted formal needs assessments, or (2) could take as much action as they believed was needed, based on the results of the needs assessments, because program funds were limited. Other barriers are more difficult to address, such as parent and administrator underestimates of AOD use among students or lack of local commitment to needs assessment activities.

Program Evaluation

The DFSCA Part B, section 5126(b)(1)(C), required districts to submit an annual progress report to the state educational agency that includes "a discussion of the method used by the applicant to evaluate the effectiveness of its drug education program carried out under its plan." Furthermore, under Section 5127(a) (3) (H) of the DFSCA, each state was required to submit to the Secretary of Education a biennial report that includes "an evaluation of the effectiveness of State and local drug and alcohol abuse education and prevention programs." In this section we describe the formal evaluation activities completed by 11 of the 19 districts studied. Included are evaluations of program components, such as student counseling and support programs; curricula used in student instruction; and programs operated by community agencies, such as the D.A.R.E. program. Apparently, a state-sponsored evaluation activity was

used to meet this requirement in the remaining eight districts. We specifically discuss the extensive evaluation efforts of three districts (District 5, 9, and 14). Interestingly, of the 12 districts that cited curriculum as a primary component of their prevention program, only 4 (Districts 5, 9, 15, and 18) had conducted curriculum evaluations. A few districts that did not report curriculum as a primary component also had conducted curriculum evaluations.

Overall, the formal evaluation activities cited by 11 study districts did not appear very rigorous or extensive. Prevalence surveys were common (7 districts), with districts comparing the results of surveys conducted in later years with those done earlier to obtain a needs assessment. Although six of these seven districts reported using the results based on comparing prevalence surveys to inform prevention planning, these data did not provide the districts with evaluation information on the specific components of their programs. Only three districts that used prevalence survey information as part of their overall evaluation efforts also conducted additional evaluations of specific program components. The activities of these 3 districts were the most extensive and well-focused of all 19 study districts and are discussed in detail below.

District 5. The district conducted numerous evaluations of its student-focused components, including three curriculum evaluations:

- In SY91-92, the prevention program coordinator surveyed teachers of grades K-12 regarding their opinions of *Clear Choices* and *Too Good for Drugs*, which were implemented in that year. Results indicated that teachers liked the curricula. The district continued to provide support (i.e., annual purchase of workbooks for elementary and middle schools) for those curricula.
- The state educational agency conducted a comprehensive review of the district's health education curriculum (8 topics) in SY91-92. The results showed that only the AOD topic was consistently delivered; some teachers thought that *Here's Looking at You, 2000* (AOD topic) was the entire health curriculum.
- In SY91-92 and SY92-93, the prevention program coordinator surveyed teachers, principals, and nurses about *Here's Looking at You, 2000* and their perceptions of student changes as a result of the curriculum's use. The coordinator had not analyzed the data because she lacked the relevant training; the surveys were used primarily to let the schools know the district cared about curriculum use.

Four other evaluations also were conducted in this district. In SY92-93, a districtwide meeting for student assistance team members was held to evaluate goals, set new ones, and

discuss effective activities. School staff used the information to refine their own programs, and one of the participating elementary schools[19] evaluated its student assistance team twice a year after that time. This school contracted for an independent evaluation of its prevention-related resource center in SY92-93. Parents were interviewed and teachers were surveyed. Preliminary results showed that students were learning better; staff were very pleased with the results. Final results were used for planning.

After SY92-93 district students in grades 8 and 10 completed an annual 15-item AOD use survey as part of the Strategic School Profile that the state required of all local boards of education. The results of the SY92-93 survey showed that the proportion of district students using AOD in the previous 30 days was smaller than the statewide proportion for all drug categories except hallucinogens. Despite these relatively positive findings, given the findings from the 1990 survey, district staff were alarmed to learn that 27 percent of high school students had recently drunk alcohol, 19 percent had recently been passengers in a car whose driver was impaired, 16 percent used tobacco products, and 11 percent had at least five drinks on one occasion. The district planned to use the results to strengthen prevention programming, especially at the middle and high school levels.

Finally, middle school counselors met with peer advocates at the end of each year to discuss successes/failures, students' desire to continue/stop being an advocate, and needs for additional training. Counselors used the information to increase program effectiveness.

District 9. This district conducted prevalence surveys and evaluated all school and community prevention components. In May 1990 the district conducted a prevalence survey, "I SAY," that was similar to its 1985 needs assessment prevalence survey. Responses from students in grades 9-12 indicated that alcohol use decreased from 70 to 59 percent, a 16 percent decline. While program staff found the results encouraging, they realized that many factors in students' lives, other than the prevention programs, may have contributed to these positive results.

In fall 1991 the prevention program's staff evaluated every school and community component. Students, parents, and other community members rated the health curriculum,

[19]In SY93-94 the U.S. Department of Education recognized this school's prevention program achievements by selecting it for the Drug-Free Schools Recognition Program.

D.A.R.E., and a student leadership and peer helping program for their (1) effectiveness over the past 3 years, and (2) likelihood of having future impacts on AOD use. Respondents indicated that they believed the components were achieving the planned goals and that they would continue to influence behavior. The program coordinator noted that the primary negative finding was a decrease in students' opinions of D.A.R.E.'s value given in grade 10 compared to those given in grade 6.

The district's survey of student athletes in grades 7-12 regarding AOD use during sports season was repeated in spring 1993, the end of the first year the prevention program targeting athletes was implemented. High school findings were in keeping with program predictions that the percentage of athletes reporting some use of alcohol would remain unchanged over the program's first 3 years and then would begin to show a decrease; specifically, about 38 percent of high school students reported some use at both points in time. However, program staff were pleased that junior high school results were ahead of schedule; students reporting use of alcohol dropped from 11 to 7 percent.

Also in spring 1993, coaches were asked to evaluate the sports drug program lessons. As a result, the program pilot tested changes in lesson delivery; test results were used to design the remaining lessons. The district tried to evaluate student attitudes toward the lessons; however, many students were not aware they had participated because coaches integrated the lessons into regular practice talks, so attitudes were difficult to assess.

Program staff continually assessed the components on the basis of achieving the program's larger goals. For example, while initial parenting seminars apparently were more successful in attracting parents than is typical in most communities of similar size, the advisory council members and prevention staff believed that a greater portion of parents needed to be reached for significant impact. As a result, the program staff changed strategies, providing training in homes and schools throughout the county rather than in a single community center. In SY92, the district received a state DFSCA exemplary program award.[20]

District 14. In this district, students participated in statewide prevalence surveys, and the prevention program coordinator designed a computer tracking and evaluation system for the

[20]Four of the participating districts (Districts 5, 9, 12, and 17) had received DFSCA awards for their programs' achievements.

prevention program to obtain information on specific activities. District students in grades 4, 7, 9, and 12 participated in statewide prevalence surveys in SY90-91 and SY92-93. Results comparing data from SY87-88 and SY90-91 for grades 7, 9, and 12 indicated declines in all categories of AOD use (i.e., past 30 days, past 7 days, and lifetime) with the exceptions of increases in weekly use of alcohol by 7th and 9th graders, and a slight increase in 12th graders' lifetime use of LSD. Overall, AOD use within the district had declined faster than it had statewide.

The program coordinator found the prevalence survey results helpful for program evaluation but not for program planning because the surveys revealed drug-specific behaviors rather than determining overall use patterns. Thus, to bolster planning, at the end of each school year each school completed a prevention plan for the coming year that: (1) outlined programs/activities conducted during the past year; (2) identified needs for the coming year; (3) identified activities planned for the coming year; and (4) noted changes they would like to see in the district's prevention program. The plan was divided into nine sections, each tied to DFSCA standards (Section 5145 of the DFSCA).[21]

The school-level prevention plans were part of a tracking and evaluation system established in SY91-92 by the program coordinator. The computer-based system tracked students from school to school, service to service, and year to year, thus recording all prevention activities in which each student participated. Tracking assured that students who changed schools continued to receive prevention services comparable to those obtained at their old school. New schools could access this information on line or through a computer-generated list sent from the prevention office. Student records were maintained until the student graduated or left the district. The computer-based system also documented the effectiveness of program components. The results were reported to individual schools, program administrators, the school board, and the state education agency.

[21]The standards are: (1) offer age-appropriate, developmentally based AOD education and prevention programs for all students, (2) convey "no use" message to students, (3) apply standards of conduct to all students, (4) apply disciplinary sanctions for violation of conduct standards, (5) inform students of any available AOD counseling and rehabilitation programs, (6) provide parents with a copy of the standards, (7) notify parents and students that compliance with the conduct standards is mandatory, (8) ensure that disciplinary sanctions are consistently enforced, and (9) determine the prevention program's effectiveness and implement needed changes.

Four categories of data were collected and analyzed to provide both process and outcome evaluations:

- *Intake variables.* Included participation rates for various program components; data from other agencies or organizations that might be used as baselines for determining program success/failure; academic performance and attendance patterns; demographic information; and referral sources and reasons for referral.
- *Intervention data.* Included procedures used to collect the data, recommended actions, actions taken, parent permission status, special education status, service completion status, and the need for additional prevention services.
- *Assessment findings.* Included information on the identified problem, procedures used to identify the problem, and high-risk indicators. These data were collected for intervention programs.
- *Outcome data.* Included pre/post tests or surveys about specific program activities; knowledge, affective, and/or behavioral indicators; attendance patterns; and data from other programs or organizations. Outcome follow-up information could be collected in both the short and long term.

Information from this system was used to evaluate program components and to inform program planning. Results (SY91-92) for the primary components of the district's prevention program led to decisions to increase the numbers of staff in particularly effective components of the prevention program, including a program for students who violated the district's substance abuse policy, and the support groups for students at risk for AOD use.

Other Districts. Of the nine remaining districts that reported formal evaluation activities, one district collected a great deal of process-oriented data from its schools and used the information primarily to determine training needs. Data also were collected on AOD-related incidents, and several schools used a student attitude survey as part of their end-of-year reports to the district. Additionally,

- Three districts participated in prevalence surveys but in no other evaluation-related activities.
- One district participated in an annual statewide prevention program evaluation beginning in SY90-91. However, our interviews revealed that a majority of school-level staff did not find the evaluation results useful.
- Another district asked teachers to evaluate annually the effectiveness of the D.A.R.E. officers' presentations.
- Two districts conducted evaluations of specific instructional components.

- The prevention program coordinator in another district used the results of a 1992 state evaluation of 20 promising drug abuse prevention strategies to guide her development of new activities and to revise existing program components.

Surprisingly, the overall evaluation efforts of the three districts whose programs predated the DFSCA legislation (4, 12, and 13) appeared minimal. District 4 established mechanisms to obtain process data related to specific components, and schools had to submit program evaluation forms to the district annually. District 12 made use of district-sponsored prevalence surveys to refine its programmatic efforts but had not undertaken specific program component evaluations; this district's program had been in existence since 1979, had numerous school and community components, and was one of the most well-funded programs in our study. In the case of District 13, no district evaluation efforts had occurred that we know of; this program was in its twelfth year at the time of the fall 1993 visit and averaged $75,000 annually in prevention funding.

Most of our study districts could benefit from technical assistance in developing program evaluations. Districts need guidance in deciding what to evaluate, how to gather useful information, and how to use the results effectively.

Summary

Formal evaluation activities conducted by the study districts' prevention programs consisted primarily of comparing the results of prevalence surveys conducted over several years. Some districts also conducted surveys of the perceptions and opinions of students and staff regarding program effectiveness. The results of evaluations seldom led directly to program improvements, in part because many of the evaluations were not designed to produce the information that program planners needed. However, these districts reported their intent to use evaluation results in the future. Moreover, district and school drug prevention staff may not have had the requisite skills to design evaluations and analyze the data.

As is the case with needs assessment activities, it seems that districts could greatly benefit from technical assistance in designing and conducting evaluation efforts. Districts may also need encouragement to give more attention to evaluation; in the cases of districts with

limited prevention funds, program implementation will necessarily take priority, but evaluation activities can serve a useful function as well.

Summary and Conclusions

In this section we summarize the findings discussed above in the areas of program content, staffing, and evaluation, and conclude with a discussion of the factors that facilitate and impede the implementation of district programs.

Overall, DFSCA had supported widespread implementation of prevention education programs for students in these 19 study districts. Most study districts established a prevention program as a direct result of the availability of DFSCA funds; however, a few districts had prevention programs in place prior to the federal legislation. Some districts and their prevention program coordinators had well-formulated approaches toward prevention that guided the choice of program components and their implementation. The following are the major findings from our cross-site analysis.

Program Content

- The three key components that most school-based prevention programs contained were student instruction, student support, and special events. Community members and organizations could be involved in any or all of these components.
- Student instruction and special events were most often targeted to the general population of students, while student support services typically addressed the needs of specific groups of students.
- Whereas a few districts created their own prevention-specific curricula, most made use of commercial and state or locally developed prevention curricula. Moreover, nearly all districts cited the use of academic textbooks as a source of prevention education material.
- The most common forms of student support activities were peer assistance programs, student leadership programs, student assistance teams, and counselor-support groups.
- Some districts believed student support services were more important than student instruction for effecting long-term positive outcomes. One district emphasized a family-oriented approach, targeted much of its prevention resources toward support services for at-risk students, and viewed training and support for teachers as a significant contribution to its student support activities.

- Districts that believed their communities were relatively free of alcohol and other drug problems tended to rely on special events, such as Red Ribbon Week, as their primary focus for prevention.

Program Staffing

- Overwhelmingly, classroom teachers were responsible for providing prevention instruction through the use of curricula.
- In districts where prevention appeared to be a priority, release time or stipends were provided to school staff who coordinated prevention programs at the building level.
- Districts varied substantially in the amount of the prevention program coordinator's time assigned to prevention (as opposed to other duties in the district). Overall, programs that appeared consistently well implemented tended to be those whose prevention program coordinators could spend 100 percent time directing the program.

Evaluation

- Most districts had completed some form of needs assessment or program evaluation, relying primarily on prevalence surveys for their data. Few districts had specifically evaluated their key program components.
- Districts used their evaluation results primarily for program development and to generate community support and funding.

Conclusions

The overall quality of a district's prevention efforts appeared to be related to the specific components that constituted the program and the extent to which those components were implemented as planned. A distinguishing factor among districts in terms of the emphasis placed on prevention instruction was the extent to which implementors used prevention-specific curricula or relied on an AOD-related section of an academic textbook. Reliance on academic textbooks did encourage the integration of prevention throughout the total curriculum; however, the prevention information in these textbooks was often dated and is often less comprehensive than prevention-specific materials. Moreover, instructional quality was higher if delivery was

consistent and if staff who implemented a prevention-specific curriculum received training themselves, both introductory and follow up.

Programs characterized by student instruction or the conduct of special events tend to target their resources toward providing all students with some prevention education. Districts that emphasized student support activities covered a narrower segment of students more intensively, but prevention program coordinators in these districts believed their efforts were more effective when focused on a smaller, specific group of students who were most at risk for AOD use.

The 19 study districts experienced varying degrees of success in implementing their prevention programs. As we looked across these districts, we identified factors that appeared to enable successful implementation and others that seemed to impede implementation. These facilitators and barriers occurred in a variety of program structures (e.g., focus on instruction vs. student support activities) and are important to our understanding of the varying levels of success these programs achieved.

The primary factor that facilitated the implementation of a district's prevention program was *the level of commitment of the program implementors* (e.g., prevention program coordinator, teachers, counselors, other staff). Committed personnel believed in their goal of drug prevention education and strove to provide services consistently. Strength of staff commitment was enhanced by *the clarity of the approach toward prevention* that guided the district's prevention efforts (see rationale section). We found that a clearly defined approach often was related to one (and sometimes both) of the following: *community involvement in and a sense of shared responsibility for the program*, and *leadership provided by the program coordinator*. The strong involvement of a community in addressing drug prevention took the form, for example, of an advisory board or other community organization that oversaw the program or assisted with prevention activities. Alternatively, some districts used existing community organizations to deliver prevention services. Either way, community members collectively believed that drug prevention and education were not the sole responsibility of the schools and that long-term solutions to drug-related problems had to be sought by all individuals in the community. Our investigations also revealed a program greatly benefitted when a *program coordinator was assigned 100 percent of the time to prevention activities*. These programs were most often ones

with student instruction for all grade levels, coordinated staff training, and student support groups. However, having a full-time prevention coordinator did not ensure successful program implementation.

In addition to a full-time district coordinator with strong leadership abilities to direct prevention activities, other facilitating factors appeared to be: *school-based prevention coordinators, additional district staff* to assist the prevention coordinator, and an emphasis on *prevention staff training*. One district extended its training emphasis to the students involved in a youth leadership program, and a few districts provided school-based staff with stipends or release time for assuming prevention-related responsibilities. This recognition at the district level of the importance of reinforcing a school-level commitment to prevention seemed to ensure that prevention activities were a priority and were implemented with some regularity.

The most common barrier to achieving full implementation of a prevention program was a *lack of leadership by the prevention program coordinator*, a situation frequently caused or exacerbated by the *prevention coordinator having other responsibilities within the district*. Further, some *prevention coordinators did not consistently follow through* to determine exactly what activities were being implemented in the schools. Others *lacked awareness of the full spectrum of prevention strategies* that might be employed. Prevention program coordinators without such awareness relied heavily upon the D.A.R.E. program for prevention education or on Red Ribbon Week activities to define their prevention program. In a few districts, *community members did not believe there was a youth drug problem*, a perception that led to a lack of parent and community support for, or involvement in, prevention activities.

Other priorities also interfered with prevention efforts in some districts. For example, in one of the districts, district administrators (in general) were greatly concerned about increasing the number of students passing the state achievement test. This academic-related concern severely limited the ability of teachers and other staff to implement the prevention program uniformly throughout the district because class time was to focus primarily on academics. In another district, prevention efforts were overshadowed by teacher contract negotiations and financial constraints. Finally, the efforts of some prevention program coordinators were constrained by their districts' moves toward site-based management. In these districts, principals and their staffs had autonomy in determining the scope of their prevention activities,

and even a committed program coordinator with a clearly defined approach to prevention could not ensure that a comprehensive prevention program was implemented districtwide.

Attachment A

Drug-Free Schools and Communities Act of 1986 as Amended in 1989 (P.L. 101-226)

Attachment A

Drug-Free Schools and Communities Act
of 1986 as amended in 1989 (P.L. 101-226)

Title V - Drug Education
Part B - State and Local Programs

§ 5125 Local drug abuse education and prevention programs

(a) in general

Any amounts made available to local or intermediate educational agencies or consortia under section 5124(a) of this title shall be used for drug and alcohol abuse prevention and education programs and activities, including —

(1) the development, acquisition, and implementation of elementary and secondary school drug abuse education and prevention curricula and textbooks and materials, including audio-visual materials —

(A) developed from the most readily available, accurate, and up-to-date information; and

(B) which clearly and consistently teach that illicit drug use is wrong and harmful;

(2) school-based programs of drug abuse prevention and early intervention (other than treatment, which—

(A) should, to the extent practicable, employ counselors whose sole duty is to provide drug abuse prevention counseling to students;

(B) may include the use of drug-free older students as positive role models and instruction relating to—

(i) self-esteem;
(ii) drugs and drug addiction;
(iii) decisiomnaking and risk-taking;
(iv) stress management techniques; and
(v) assertiveness;

(C) may bring law enforcement officers into the classroom to provide antidrug information and positive alternatives to drug use, including decisionmaking and assertiveness skills; and

(D) in the case of a local educational agency that determines it has served all students in all grades, such local educational agency may target additional funds to particularly vulnerable age groups, especially those in grades 4 through 9.

(3) family drug abuse prevention programs, including education for parents to increase awareness about the symptoms and effects of drug use through the development and dissemination of appropriate educational materials;

(4) drug abuse prevention and intervention counseling programs (which counsel that illicit drug use is wrong and harmful) for students, parents, and immediate families, including

professional and peer counselors and involving the participation (where appropriate) of parents, other adult counselors, reformed abusers, which may include—

(A) the employment of counselors, social workers, psychologists, or nurses who are trained to provide drug abuse prevention and intervention counseling; or

(B) the provision of services through a contract with a private nonprofit organization that employs individuals who are trained to provide such counseling;

(5) outreach activities, drug and alcohol abuse education and prevention programs, and referral services, for school dropouts;

(6) guidance counseling programs and referral services for parents and immediate families of drug and alcohol abusers;

(7) programs of referral for drug abuse treatment and rehabilitation;

(8) programs of inservice and preservice training in drug and alcohol abuse prevention for teachers, counselors, other school personnel, athletic directors, public service personnel, law enforcement officials, judicial officials, and community leaders;

(9) programs in primary prevention and early intervention, such as the interdisciplinary school-team approach;

(10) community education programs and other activities to involve parents and communities in the fight against drug and alcohol abuse;

(11) public education programs on drug and alcohol abuse, including programs utilizing professionals and former drug and alcohol abusers;

(12) model alternative schools for youth with drug problems that address the special needs of such students through education and counseling; and

(13) on-site efforts in schools to enhance identification and discipline of drug and alcohol abusers, and to enable law enforcement officials to take necessary action in cases of drug possession and supplying of drugs and alcohol to the student population;

(14) special programs and activities to prevent drug and alcohol abuse among student athletes, involving their parents and family in such drug and alcohol abuse prevention efforts and using athletic programs and personnel in preventing drug and alcohol abuse among all students;

(15) in the case of a local educational agency that determines that it provides sufficient drug and alcohol abuse education during regular school hours, after-school programs that provide drug and alcohol abuse education for school-aged children, including children who are unsupervised after school, and that may include school-sponsored sports, recreational, educational, or instructional activities (local educational agency may make grants or contracts with nonprofit community-based organizations that offer sports, recreation, education, or child care programs); and

(16) other programs of drug and alcohol abuse education and prevention, consistent with the purposes of this part.

Attachment B

Prevention-specific Curricula

ATTACHMENT B

Attachment B lists the non-academic, commercially-developed, textbook curricula[1] used by the various study districts.

Commercially Developed Programs (38 total)

Al-Anon, Lois W. and Ann B., Al-Anon Family Groups Headquarters, P.O. Box 862 Midtown Station, New York, NY 10018-0862 (800) 356-9996

Al-Ateen, Lois W. and Ann B., Al-Anon Family Groups Headquarters, P.O. Box 862 Midtown Station, New York, NY 10018-0862 (800) 356-9996

BABES, 17330 Northland Park Ct., Southfield, MI 48075 (800) 542-2237

Change, Dr. Lynn Krebs, Milwaukee Public Schools, 5225 W. Vliet St. Rm. 268, Milwaukee, WI 53208 (414) 475-8142

Children Are People (CAP), 3201 SW 15th St., Deerfield Beach, FL 33442 (800) 851-9100

CLOWNS, Karola Alford and Gloria Leitschuh with Central East Alcoholism and Drug Council, 521 North 13th St., Mattoon, IL 61938 (217) 258-6137

CHAMPS, Pat Epps and Allison Vallenari, 14425 N. Scottsdale Rd., Ste. 400, Scottsdale, AZ 85254-3449 (602) 991-9110

Children of Alcoholics (COA), Children of Alcoholics Foundation, 555 Madison Ave. 20th Floor, New York, NY 10022 (800) 359-2623

Clear Choices, The C.E. Mendez Foundation, Inc., P.O. Box 10059, Tampa, FL 33679 (813) 251-3600

Conflict Managers, (Conflict Resolution Resources for Schools and Youth), Community Board Program Inc., 1540 Market St. Ste. 490, San Francisco, CA 94102 (415) 552-1250

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[1]Twelve of the 19 districts use academic textbooks (e.g., health, science, social studies, home economics) as a source for prevention education. Based on the grade levels in which districts report textbook use, prekindergarten through eighth grade, and assuming that a different text is likely to be used at each grade level, we estimate that nearly 100 different academic textbooks are being used for prevention education in our study districts. Academic textbooks are not reflected in Attachment B.

Conflict Resolution/Peer Mediation, Peace Education Foundation Curriculum, Peace Education Foundation, Inc., 2627 Biscayne Blvd., Miami, FL (305) 576-5075

Second Step, Committee for Children, 172 20th Ave., Seattle, WA 98122 (206) 322-5050

Conflict Resolution, The Community Board Program, 1540 Market St. #490, San Francisco, CA 94102 (415) 552-1250

Violence Prevention Curriculum for Adolescents, Education Department of Public Health, 55 Chapel St., Newton, MA 02160 (617) 552-7058

DARE, P.O. Box 2090, Los Angeles, CA 90051-0090 (800) 223-3273

Discover, American Guidance Service, P.O. Box 99, Circle Pines, MN 55014 (800) 888-5111

Education for Self-Responsibility, Texas Education Agency, Publications Distribution Office, 1701 N. Congress Ave., Austin, TX 78701 (512) 463-9734

Esteem Builders, Jalmar Press, 2675 Skypark Dr. Ste. 204, Torrance, CA 90505 (310) 784-0016

GREAT, Phoenix Police Department with Mesa Police Dept., Tempe Police Dept., and Glendale Police Dept., 620 West Washington, Phoenix, AZ 85003 (602) 495-0431

Growing Healthy, National Center for Health Education, 72 Spring St. Ste. 208, New York, NY 10012-4019 (212) 334-9470

Here's Looking At You 2000, CHEF (Comprehensive Health Education Foundation), 22323 Pacific Hwy. South, Seattle, WA 98198 (800) 323-2433

Just Say No International, 2101 Webster St. Ste. 1300, Oakland, CA 94612 (800) 258-2766

McGruff, National Crime Prevention Council, 1700 K St. NW 2nd flr., Washington, D.C. 20006 (202) 466-6272

Natural Helpers, CHEF (Comprehensive Health Education Foundation), 22323 Pacific Hwy. South, Seattle, WA 98198 (800) 323-2433

Ombudsman, Drug Education Center, 1117 E. Morehead St., Charlotte, NC 28204 (704) 375-3784

Operation Aware, Central Administration Building of the Duluth Public Schools, 215 N. 1st Ave. E., Duluth, MN 55802-2069 (218) 723-4180

Peer Mediation, NAME (National Association for Mediation Education), UMASS-Amherst, 205 Hampshire House, Box 33635, Amherst, MA 01003 (413) 545-2462

Positive Action, Positive Action Publishing, 321 Eastland Dr. Box 2347, Twin Falls, ID 83303-2347 (800) 345-2974

The Power of Positive Students, POPS International Foundation, Inc., P.O. Box 20037, Myrtle Beach, SC 29575 (800) 521-2741

Project Adventure, National Headquarters, P.O. Box 100, Hamilton, MA 01936 (508) 468-7981

Pumsy, (Building Self-Esteem Skills with Pumsy), Timberline Press, Inc., P.O. Box 70187, Eugene, OR 97401 (503) 345-1771

Quest-Skills for Adolescence, Quest International, 537 Jones Rd., P.O. Box 566, Granville, OH 43023-0566 (614) 522-6400

Quest-Skills for Growing, Quest International, 537 Jones Rd., P.O. Box 566, Granville, OH 43023-0566 (614) 522-6400

Refusal Skills (The Skill Life Program), Elliott Herman and CHEF (Comprehensive Health Education Foundation), 22323 Pacific Hwy. South, Seattle, WA 98198 (800) 323-2433

Say No and Fly Away, New Dimensions In Education, 61 Mattatuck Heights, Waterbury, CT 06705 (800) 227-9120

Self-Esteem in the Classroom, The Canfield Group, 6035 Bristol Pkwy., Culver City, CA 90230 (310) 337-9222

Skillstreaming the Adolescent, Research Press, 2612 N. Mattis Ave., Champaign, IL 61821 (217) 352-3273

SRA Self Development, Science Research Associates, 155 N. Wacker Dr., Chicago, IL 60606 (312) 984-7000

STAGES, Irvine Unified School District, Guidance Resources Office, 5050 Barranca Pkwy., Irvine, CA 92714 (714) 552-4882

Too Good for Drugs, The C.E. Mendez Foundation, Inc., P.O. Box 10059, Tampa, FL 33679 (813) 251-3600

Turning It Around, The Dave Winfield Foundation, One Bridge Plaza Ste. 400, Fort Lee, NJ 07024 (201) 592-5031

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Office of Educational Research and Improvement (OERI)
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